

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2373

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 64

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY St. Francis |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Leadwood  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4448a Labadie                                  |  | d. STREET ADDRESS (If rural, give location) NIV  |  |

|  |                        |  |   |   |                             |                                 |
|--|------------------------|--|---|---|-----------------------------|---------------------------------|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Edna b. (Middle) c. (Last) Coffman                   |                        |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>1-4-50 |   |                             |                                 |
| 5. SEX Female  | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 23, 1899                 | 9. AGE (In years last birthday) 50                                | IF UNDER 1 YEAR Months Days | IF UNDER 4 HRS. Hours Min.      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife |                        | 10b. KIND OF BUSINESS OR INDUSTRY At Home                      |   | 11. BIRTHPLACE (State or foreign country) Mineral Point, Missouri |                             | 12. CITIZEN OF WHAT COUNTRY USA |

|                                    |  |  |
|------------------------------------|--|--|
| 13a. FATHER'S NAME William Politte | 13b. MOTHER'S MAIDEN NAME Minerva Marler | 14. NAME OF HUSBAND OR WIFE Noah Coffman |
|------------------------------------|--|--|

|   |                              |   |
|---|------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NTL | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rosie Hussey, 4448a Labadie |
|---|------------------------------|---|

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|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage  |  | INTERVAL BETWEEN ONSET AND DEATH 1 day |
|  | ANTECEDENT CAUSES<br>Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterial Hypertension (Cerebral stroke - 6 mo past). DUE TO (c) |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |  |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 102 |
|--|--|---|

|  |  |                                 |
|--|--|---------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 331X |
|--|--|---------------------------------|

I hereby certify that I attended the deceased from Dec 31, 1949, to June 4, 1950, that I last saw the deceased alive on Jan 9, 1950, and that death occurred at 8:30 m., from the causes and on the date stated above.

|   |                                |                         |
|---|--------------------------------|-------------------------|
| 22a. SIGNATURE (Degree or title) J. P. Reicher M.D. | 23b. ADDRESS 2505 N. Florsheim | 23c. DATE SIGNED 1-4-50 |
|---|--------------------------------|-------------------------|

|   |                  |                                    |  |
|---|------------------|------------------------------------|--|
| 24a. BURIAL, CREMATION, RECOVERY (Specify) Burial | 24b. DATE 1-4-50 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) Leadwood, Missouri |
|---|------------------|------------------------------------|--|

|                                     |                                   |  |
|-------------------------------------|-----------------------------------|--|
| DATE REC'D BY LOCAL REG. JAN 4 1950 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Honne 4700 Washington |
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UNFADING BLACK INK—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Robert M Murray*

Licensed Embalmer No.

*3749*

P. O. Address

*St Louis, Mo*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.